THE

PIGMENTARY SYPHILIDE

BY

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AT THE COLLEGE OF PHYSICIANS AND SURGEONS, NEW YORK

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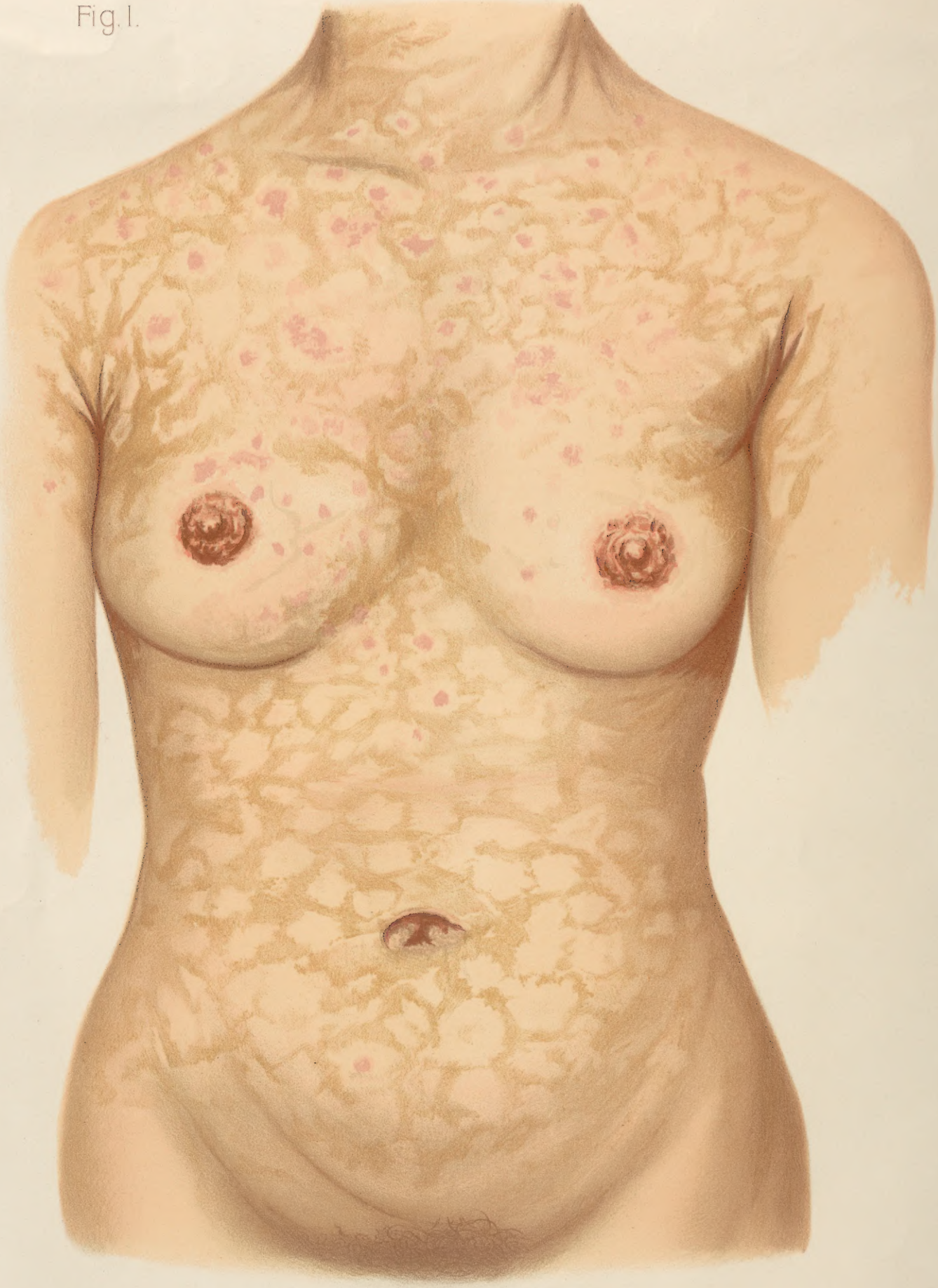
Fig. I.



Dr. Taylor's Article on the Pigmentary Syphilide.

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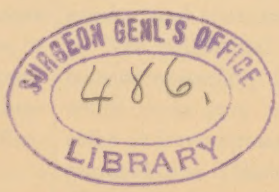

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THE PIGMENTARY SYPHILIDE.*

THE history of the pigmentary syphilide is a most peculiar one. It is an affection which at first was clearly and sharply described, but which in the course of time has been rendered so obscure that to-day very few have clear and precise ideas as to its course and its nature. In the whole range of syphilography there is not a like instance in which the knowledge of a manifestation of syphilis has become so progressively obscure and in which so much confusion has been interjected by reason of the successive additions to its literature by many writers. In the sixties we knew what the pigmentary syphilide was as a result of the writings of Hardy, Fournier, Pillon, and Tanturri. To-day this well-marked and peculiarly characteristic affection is so little understood that it is confounded with the pigmentations and the leucodermatous conditions left as a result of previous syphilitic processes. The writings of Neisser, Riehl, Ehrmann, Poelchen, and Szadeck have had much to do with the obscuration of this question, for these authors regard any pigmentation or leucodermatous condition primary or secondary to a previous syphilitic process as examples of the pigmentary syphilide.

We can not too strongly insist upon the necessity of holding fast to the postulate that the pigmentary syphilide is a unique, well-marked affection, having a sharply defined pathological basis and a course attended by well-demonstrated morphological changes. As a corollary of this, I may add that secondary pigmentations and leucodermatous conditions occurring in the course of syphilis, as relics or sequelæ of lesions chiefly secondary, are in no sense examples of the pigmentary syphilide; they are simply dischromatous accidents and not sharply defined essential affections.

The reasons why this confusion has been induced are many, and the chief ones are the following:

1. Many of the writers have had little experience in the study of syphilis, and have written in a dogmatic manner from the observation (and that usually very limited as to time) of one or perhaps two cases.

2. Conclusions have been drawn from clinical appearances presented at various stages in the progress of the affection, which, being of long duration and presenting at different periods varying pictures, can not be well understood by any one unless he has had his case or cases under his observation during the whole period of development, evolution, and involution of the affection.

3. With one exception (Maieff), authors have studied the question from a histo-pathological basis in a haphazard way, but have been none the less dogmatic in their conclusions. Thus no observer until Maieff's time studied the disease microscopically step by step in accordance with its natural evolution. On the contrary, sections of skin were made indiscriminately in cases of secondary pigmentations and leucodermatous conditions, and perhaps in cases of the true pigmentary syphilide. In no instance is any distinction observed. In this way discrepancies have been produced, and flat contradictions and anomalies have resulted.

4. Every pigmentation in a syphilitic, recent or old, is called the pigmentary syphilide, and the latter is thus deprived of its essential character.

For many years I have carefully studied the affection upon a large number of patients, in many instances during its whole course, and I venture to present my conclusions, now feeling confident that they are correct and with the hope that the light on this subject here offered may extend and do something to dissipate the prevailing doubt, obscurity, and confusion.

The primordial pigmentary anomalies due to syphilis consist essentially in a superpigmentation, which may in whole or in part be replaced by a corresponding loss of color or leucodermatous condition. This primordial hyperpigmentation is the essential pigmentary syphilide; all other discolorations are secondary processes and in no manner entitled to be classed as pigmentary syphilide.

The pigmentary syphilide is seen in three well-marked and quite distinct conditions:

1. In the form of spots or patches of various sizes.

2. As a diffuse pigmentation of greater or less intensity, which sooner or later becomes the seat of leucodermatous changes in the shape of small spots which gradually increase in size. This is the retiform pigmentary syphilide—the *syphilide pigmentaire à dentelles* of Fournier.

3. In an abnormal distribution of the pigment of the

* Read before the American Association of Genito-urinary Surgeons, June 21, 1892.

skin, in which, owing to the lack of or crowding out of the pigment in places, they become whiter, while the parts involved in the abnormal distribution become darker; in this way a dappled appearance is presented. In this form there is probably no excess of pigment; it is seemingly unequally distributed throughout the tissue expanse. This form has been termed the marmoraceous, from its resemblance to some forms of marble in which there is an intimate interblending of light and darker colors. This marmoraceous pigmentary syphilide is not common, and it is peculiarly liable, by reason of its delicacy of tone and tint, to pass unobserved.

The pigmentary syphilide in the form of spots or patches consists of round, oval, or irregular plaques, which may have sharply defined borders or their margins may be dentated or jagged. Their color varies from a light-brown *café au lait* to even a quiet deep brown tint. They are unaffected by pressure and the condition of the circulation. In persons of light and delicate skin they may be very faint in tint and perhaps only perceptible in oblique light. In Fig. 3 an admirable picture of the spot-form pigmentary syphilide is shown. In this case the pigmentation was very deep. It was under my observation for a long time, during which I observed its evolution as pin-head-size spots, which increased in area until they reached the size shown in the figure. In this woman this eruption appeared toward the end of the first year of syphilis. Prior to its onset the neck had not been invaded by syphilitic lesions of any form; consequently this eruption was not a posthumous expression of an antecedent eruption.

In this form of pigmentary syphilide it is common to see the uneven distribution of the pigmentation; sometimes the color is deeper at the margin. Commonly there is no involvement of the intervening skin, though sometimes the hyperchromatous condition produces the illusion that the unaffected skin is whiter than normal. These pigmented spots may remain unchanged and indolent for months, particularly in cold weather. In the course of time they show evidence of fading and they slowly disappear. The process of involution may begin at the margin and extend centripetally, or it may take place in the whole morbid area. In some cases colorless patches are left after the disappearance of the pigmentation; there is then produced a secondary or pseudo-leucoderma. Now, if a case is seen only in this stage, I can well understand an observer reaching the conclusion that the process was an atrophic one; consequently it is easy to see why so much is written upon syphilitic leucoderma and syphilitic vitiligo. These expressions clearly show the want of a full knowledge of the disease, and that the observer has only acquainted himself with its stage of decline. In most cases the skin retains its normal appearance after the full involution of this syphilide. In Figs. 4 and 5 is well shown a disseminated eruption of pigmented spots which followed a papular syphilide. This is an excellent illustration of secondary pigmentation.

The second form of pigmentary syphilide—the lace or retiform variety—is far more common than the previous form. More or less slowly and even rapidly the sides of the neck become discolored, the tint being that of *café au lait*, or even of decided yellowish brown. The most common site of this eruption is on the sides of the neck and perhaps on the back of the neck. The patients usually say that they noticed, or were told, that their necks were getting or had got dirty. Intelligent and observant patients will very often distinctly state that their trouble began with a browning of the skin, and they will state positively that there was no intermingling of white spots. From the neck this eruption may extend more or less extensively over the trunk, mostly anteriorly or down the arms. I have never seen it go up on the face. In many cases this eruption passes unnoticed and may be attributed to the action of the sun, to irritation, or even to uncleanliness. When the pigmented patch has involved more or less of the sides of the neck a peculiar change will be observed in it—namely, the development of whitish spots which may be taken for leucoderma. Scattered irregularly over the pigmented surface close observation will show a few or many minute white specks, which in a short time, particularly in hot weather, will be large enough to present definite shapes, which may be round, oval, linear, or irregular. These white spots gradually grow, and in many instances the neck is largely covered with them before the patient knows of any change having taken place. They then say or are told that their necks are growing white. Undoubtedly many a doctor, upon this information being given him, has concluded that he has a case of leucoderma before him. Sometimes the white patches are distinctly lighter than the normal skin; in other instances the contrast between dark and light is illusory, and there is really no difference in color between the so-called leucodermatous patches and the unaffected skin. The white spots may or may not be sharply marginated, in some cases the line of margination being clear and sharp and in others indistinct. I have never seen the thin, filmy, superpigmented area around white patches of true pigmentary syphilide which we see so clearly and so commonly at the circumference of patches of leucoderma or vitiligo, as it is called. This point, in my judgment, is of diagnostic import, and is explained by the pathology of the disease to be considered further on. The tendency of the white spots to extend necessarily means the diminution of the brown background. In this way we have various pictures presented, as shown in Figs. 1 and 2. In this way is produced a dappled appearance, which warrants the name for this eruption at this time of the *dappled syphilide*. Toward the final stage of the disease the preponderance of the white spots leaves only round, oval, or wavy lines or strands of brown pigment, which gives the appearance of lace with large meshes, the interstices being formed by the white spots, which are round, oval, gyrate, linear, or irregular. In this way the skin in the course of months, and in some cases of a year or more, gradually seemingly returns to its normal condition. In the study of these cases I have sometimes seen during the activity of the process a mild and ephemeral hyperæmia, which might easily have escaped observation, and the question suggests itself to my mind whether or not a mild form of congestion may precede the hyperpigmentation.

In Fig. 1 this form of the pigmentary syphilide is well

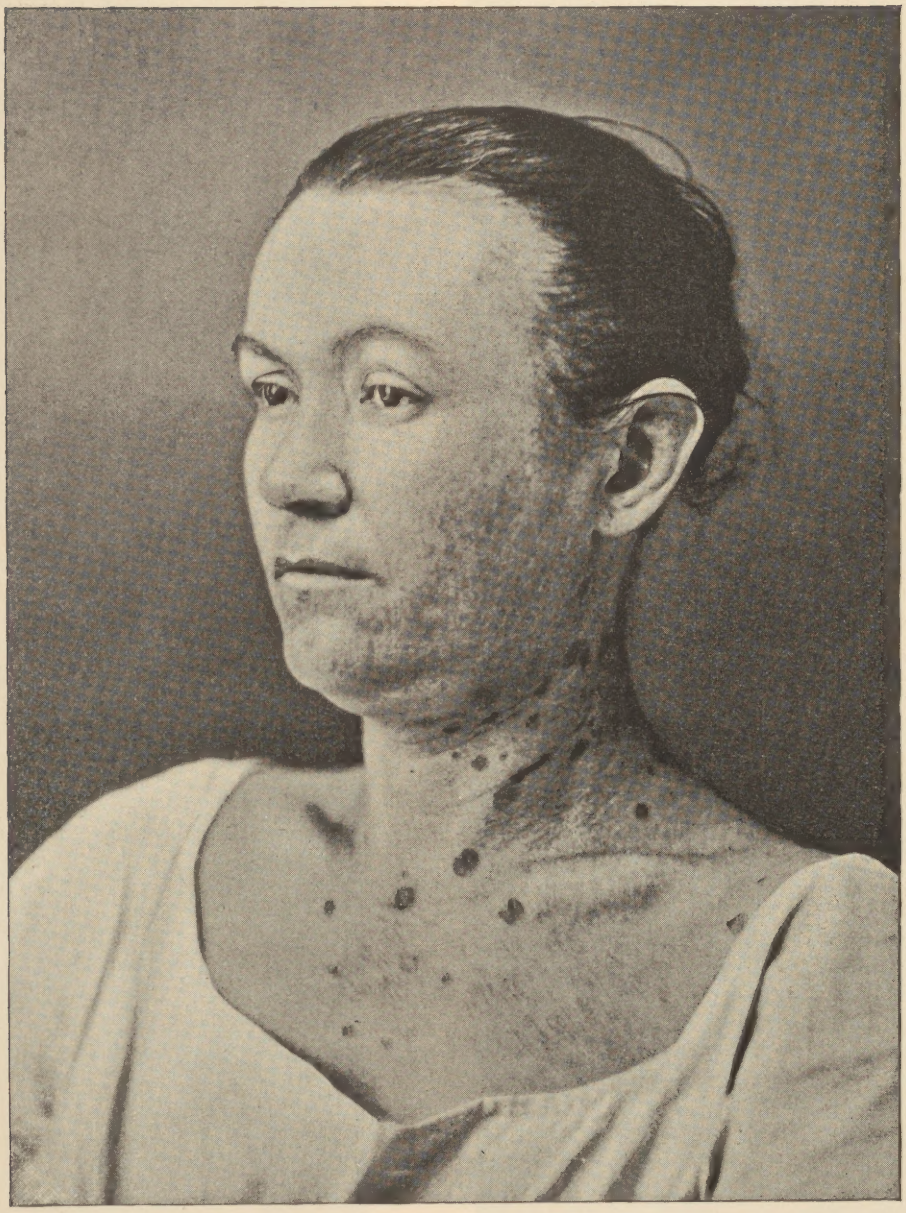

Fig. 2.—Spotted form of pigmentary syphilide.

Fig. 3.—Retiform pigmentary syphilide.

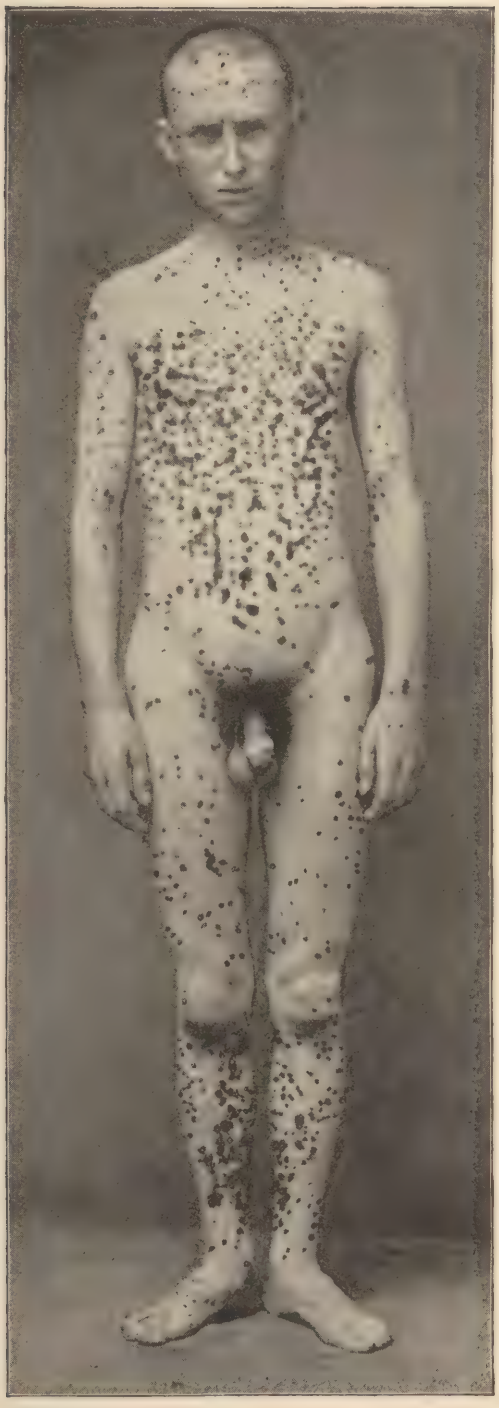

Fig. 4.

Fig. 5.

Pigmentations secondary to the papular syphilide.

shown covering the neck, the anterior and lateral parts of the trunk, and the anterior surface of the arms as far as the insertion of the deltoids. This case is remarkable and exceptional and well merits record. It was that of a girl, nineteen years old, who had two large vulvar chancres. At the date of evolution of the secondary manifestation she had a mild roseola upon the forehead, lower part of the neck, and of the whole chest. The back was quite well covered, as were also the thighs. She also had pharyngitis. With the evolution of the roseolar eruption the pigmentary syphilide began upon the neck, and within three weeks the whole anterior portion of the trunk was invaded from above downward. In the course of a month involution began around the roseolar spots and also upon the abdomen, where there were no spots. The appearances as shown in the lithographic plate are so clear and striking that further description is not necessary. Here, then, we have a well-marked instance of the coeval appearance of the roseolar and pigmentary syphilide at the very onset of the secondary stage. In six months no evidence of pigmentation could be found on this girl's body. She also suffered from analgesia of the backs of the hands and fingers. This case stands out strongly in refutation of the assertion—based, I think, on faulty and limited observation—that the pigmentary syphilide always and invariably follows in the wake of some other syphilitic process, exanthematous or papular. From all these facts and considerations I am at a loss to understand why two opinions can be held regarding this affection which is so decidedly uniform in its development, course, and decline.

The third or marmoraceous form of pigmentary syphilide is by far the least common. Its mode of invasion is slow and aphlegmasic, and there is little or no hyperpigmentation. The natural color of the skin, in spots of irregular size and shape, becomes white, while the margins, which are hazy and indefinite, become browner than normal. It seems to be a displacement of pigment resembling strikingly some delicate varieties of marble in which there are imperceptibly blended shades of white and very light black. In my experience, this form is always seen on the sides of the neck, and it does not show a tendency to extend. It can only be found upon persons of delicate skin, and very often only by close observation. It slowly disappears and the skin is left in its normal color.

As I have already stated, I attach little if any importance to the mass of literature relating to the pathological anatomy of the pigmentary syphilides, since the investigations were made in general at haphazard upon any pigmented or achromatous skin without any consideration for the stage of the process or for the clearness of the diagnosis.

Maieff's * observations, made under the direction of Professor Tarnowsky, are worthy of unqualified acceptance, for the sections of skin were taken only from patients suffering with the primary pigmentary syphilide, and the morbid process was studied upon very many sections made in tissues in all the progressive stages from its evolution to involution. Further, these microscopic studies were supplemented by prolonged and accurate clinical observation. Maieff thinks the pigmentary syphilide is due to a chronic specific inflammation of the minute blood-vessels of the skin which may be due to nutritional changes incident to the early and active period of syphilis. At its inception the morbid process consists in endothelial inflammation with cellular infiltration into the adventitia of the vessels, which are thereby diminished in caliber and even occluded. As a result of the circulatory disturbance the red blood-cells lose their pigment, which escapes and infiltrates the adventitia of the vessels, the connective-tissue cells, those of the derma and of the Malpighian layer, and even works its way into the lymphatics. During the evolution of the process most of the altered vessels become completely obliterated, the papillæ become stunted and undergo atrophy. Then the pigmentation begins to be gradually absorbed, the color of the skin grows less intense, and gradually and slowly the discoloration disappears, leaving in its wake a whitish surface.

These microscopic demonstrations, it will be seen, agree perfectly with the clinical history of the pigmentary syphilide and show beyond a doubt that this eruption has a definite and orderly mode of evolution and of involution.

In the light of its clinical history and of its pathological anatomy, it is, I think, now clearly proved that this syphilide begins as a true specific superpigmentation which is the essential feature of the morbid process, and that the subsequent leucodermatous changes are those of a degenerative nature, consequently dependent upon and secondary to the initial dischromia. It can therefore be seen how illogical and incorrect it is to call this affection syphilitic leucoderma, or syphilitic vitiligo.

It is refreshing, when one has gone through a mass of immature and unsatisfactory literature upon this subject by men who have generalized and dogmatized upon feeble and insufficient bases, to read a communication which bears evidence of patient, prolonged study by a man who starts in without bias, theory, or prejudice. Such a communication is that on the pigmentary syphilide made by Dr. Fiveisky * at the suggestion of Professor Pospeloff. (It thus happens that the most reliable and noteworthy of recent contributions to this subject have been made at the suggestion of two eminent Russian professors—namely, Tarnowsky and Pospeloff.) After an exhaustive study and research on this subject, Fiveisky has convinced himself that the disease commences with an increased pigmentation of the skin, usually of the neck, and that, after a while, there appear upon the brown surface minute circular or oval white patches or islets, which gradually increase in size and take the place of the diffuse brown pigmentation. This is in direct confirmation of what I have maintained for many years, and which has been denied by several German authors.

There are men who, by their utterances, show that they have observed little and know less concerning this syphilide,

* Contribution à l'étude de la syphilide pigmentaire. *Comptes rendus du congrès international de dermatologie et de syphiligraphie*, Paris, 1890.

* *Meditzinskoië Obozrenië*, No. 2, 1891, p. 167.

who in a flippant way pass it over, or speak of it as a curiosity unworthy of a place among the numerous manifestations of syphilis. Such a position is both faulty and unscientific. I have many times been aided in the diagnosis of syphilis by the observation of the pigmentary syphilide when all the other early manifestations had disappeared (even the ganglia in some cases were not sufficiently enlarged to offer aid in diagnosis). So that to me a knowledge of the clinical history of the syphilide has been important and helpful. I am therefore glad to see that Fiveisky says (and his opinion is indorsed by Professor Pospeloff and Dr. Jebüneff) that this syphilide constitutes one of the most characteristic and most reliable diagnostic signs of condylomatous syphilis (that is, of syphilis in the secondary stage).

Before a man makes dogmatic statements and takes a stand hereafter in this question of the pigmentary syphilide he must show, first, that he is well versed in dermatology and syphilography in order that we may feel confident of his diagnosis; second, he must show a full knowledge of the secondary pigmentary and leucodermatous conditions observed in syphilis; third, he must give evidence that he has seen at least ten typical cases of this syphilide, and that he has observed and recorded its varying appearances and features from the time of its first invasion until its final disappearance; fourth, he should, if possible, study (or have some competent person in histology study for him) the varying pathological changes beginning in the brown stage and running through the course of the disease until its final extinguishment. I hope my readers will insist upon the fulfillment of at least the first three of these requirements. If they will do this, they will see in future fewer of the jejune and misleading essays upon the pigmentary syphilide. For my own part, I like, for the sake of completeness, to append to an essay of the size of this one a complete bibliography, but, though I have it under my hand, in charity I refrain from inflicting it upon my readers. There have been published, however, within the past ten years a few essays of some merit, besides those above quoted, on this subject, but they have not been of such striking character that I deem them worthy of special mention.